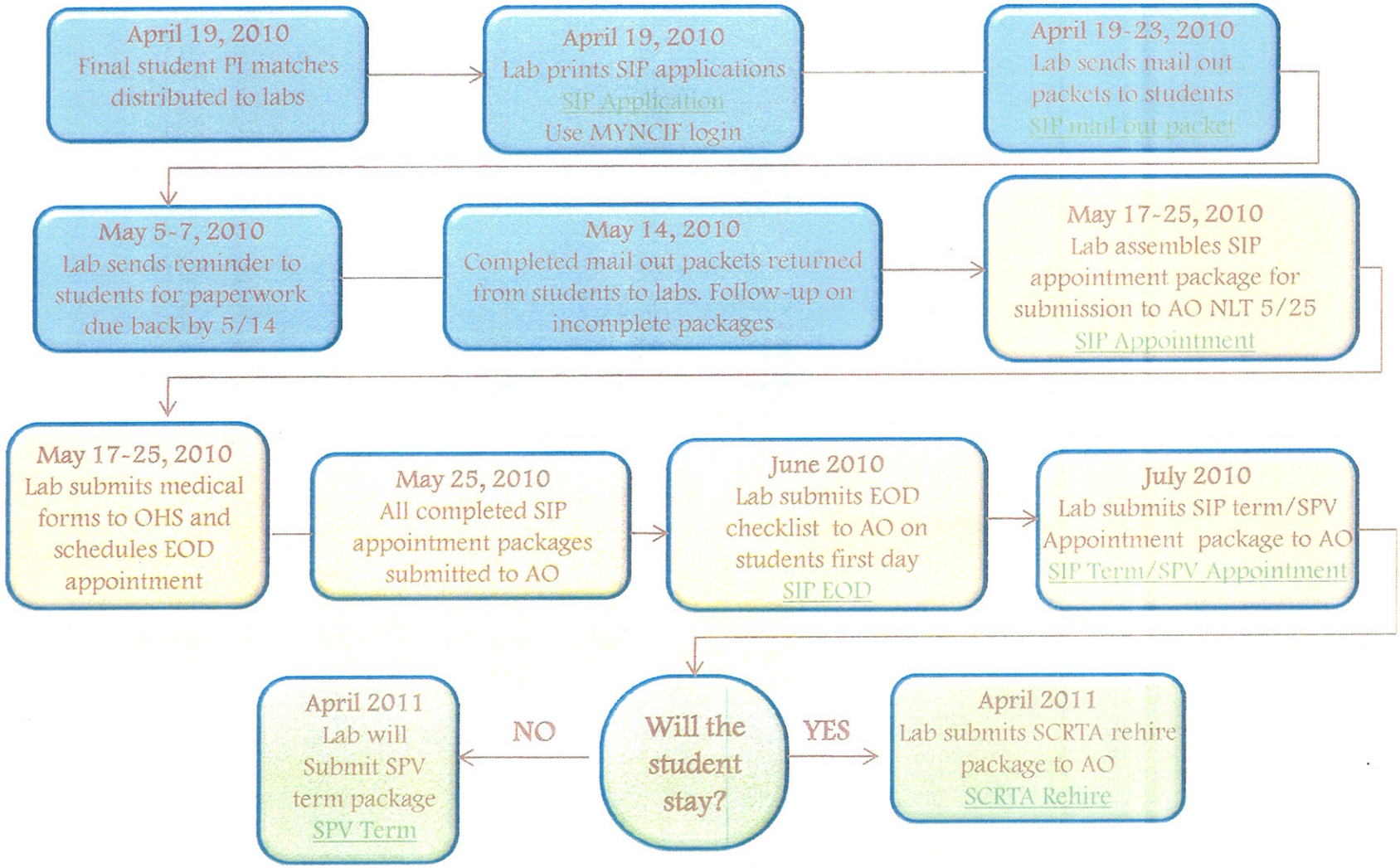
Werner H. Kirsten Student Internship Program (SIP)

March 2, 2010

Important Reminders

- Paid internship award
  - The total prorated amount MUST be the same for all students
  - SIP CAN (8333611)
  - ARC will notify the lab administrative staff on award amount after the May stipend increase is known
  - Vacations will be handled consistently
- Occupational Health Services (OHS)
  - Confidentiality of student information
  - All OHS forms submitted together for each student
  - Schedule appointment for EOD day
- Enter on Duty Items
  - Obtain both Frederick & PIV Badges
  - Complete online training courses and obtain certificates
  - Sign FPS forms
  - Complete and sign Training Plan
- Adhere to Timeline and Due Dates
- Please contact your AO for any questions/concerns regarding the SIP Program

Timeline and Tools



ARC website

Werner H. Kirsten Student Intern Program Required Documents from Students

Documents mailed to student	Completed documents returned by student	Document: To be included in appointment package to ARC
☐		Award Letter
☐	☐	SIP Return Mail Checklist
☐		Provisions
☐	☐	Agreement to Provisions
☐	☐	SF-3881 ACH Payment
☐	☐	SF-181 Ethnicity and Race Identification
☐	☐	SF-256 Self Identification of Handicap
☐		Office of Equal Opportunity & Diversity Management Reading
☐		Sexual Harassment Reading
☐	☐	Sexual Harassment Certification
☐	☐	HHS 745 ID Badge Request Form with Parental Consent Attachment
☐	☐	Parental Consent Letter

OHS Forms: To be forwarded by Lab Administrator to OHS NLT May 21st and make appointment for student's EOD date

☐	☐	SF-93 Report of Medical History
☐	☐	Documentation of Immunizations
☐	☐	OHS Employee Information Form
☐		OHS Notice of Privacy Practices
☐	☐	Acknowledgement of Receipt of Notice of Privacy Practices
☐	☐	Authorization and Medical Release for a Minor at the NCI-Frederick **(Note: Sponsor must complete Part 1 of the form before sending to the intern)**

NCI-FREDERICK CHECKLIST
WERNER H. KIRSTEN SIP APPOINTMENT
SUBMIT TO ARC: NLT MAY 26, 2010

Print Form

Fellow's Name: _____

Lab/Branch: _____

Fellowship No: _____

Effective Date: _____

Prepared By: _____

Note to ARC: Submit the original package with documents in a manilla folder with the ~~CCR~~ DCTD route slip attached to the front cover ~~and the BMS attached to the left inside of folder.~~

Complete	N/A	Required Form/Document (assemble package as follows)
1. ☐		~~CCR~~ DCTD Routeslip - required for ~~CCR Labs~~ DCTD
2. ☐		~~BMS Report - *ARC will complete*~~
3. ☐		FPS Generated Request Form - ARC Generates
4. ☐		SIP Provisions - do not need to provide copy to ARC; maintain copy with lab file
5. ☐		SIP Agreement to Provisions - ARC needs original
6. ☐		Award Notification Letter - provide copy to ARC
7. ☐		SF-256 Self Identification of Handicap
8. ☐		SF-181 Ethnicity and Race Identification
9. ☐	☐	ACH form
10. ☐		HHS-745 ID Badge Request Form
11. ☐		SF 2866 Position Sensitivity Worksheet
12. ☐		Personnel Data Sheet
13. ☐	☐	Copy of Health Insurance card
14. ☐		Sexual Harassment Certification
15. ☐		Parental Consent Letter

THE FOLLOWING ITEMS ARE FOUND ON THE ONLINE APPLICATION:

16. ☐		Resume or CV/Bibliography
17. ☐		Copy of school transcript
18. ☐		2 Letters of recommendation
19. ☐	☐	Documentation of permanent resident status - required for non U.S. citizens

20. Reminder — View the ARC's Entry-On-Duty (EOD) checklist for additional requirements:
NCI-Frederick ARC EOD checklist

NCI-FREDERICK CHECKLIST
WERNER H. KIRSTEN SIP ENTRY-ON-DUTY (EOD)

Print Form

Appointee's Name: _____

EOD: _____

Prepared By: _____

Complete	N/A	Required Form/Document (assemble package as follows)
		Lead time to OHS - NLT May 21st; also make an appointment with OHS for student's EOD date
1. ☐		Send completed OHS forms to Carolyn Cable, OHS, bldg 427 AND schedule physical with OHS (x1096) for EOD date SF-93 Report of Medical History Documentation of Immunizations OHS Employee Information Form Acknowledgement of Receipt of Notice of Privacy Practices Authorization and Medical Release for a Minor at NCI-Frederick
		Lead time to ARC - appointee's EOD date
2. ☐		ID Card/Cardkey request; appointee takes to Sharon Fritz, bldg. 426, between 9:00 and 11:00 am
3. ☐		Vehicle Registration Form to obtain vehicle decal; handcarry to Bldg. 1520
4. ☐		E-mail Cathy Simpson (Mailroom) to establish appointee's mailing address, include appointee's name, building, room, extension, and sponsor
5. ☐	☐	FAES forms - if applicable; *submit to ARC* Blue Cross/Blue Shield Enrollment Form FAES Confirmation Form
6. Reminder		Appointee should view the NCI-Frederick Getting Started Website for helpful information as well as a list of MANDATORY training
		Lead time to ARC - Within 1st week of appointee's EOD date
7. ☐		Updated Personnel Data Sheet (if changes) - *submit to ARC*
8. ☐		Training Plan
9. Reminder		Schedule fingerprinting appointment (301-228-4501) once notified by AO or NED generated e-mail

NCI-FREDERICK CHECKLIST
WERNER H. KIRSTEN SIP TERMINATION/SPECIAL VOLUNTEER APPOINTMENT CONVERSION
SUBMIT TO ARC: NLT JULY 16, 2010

Print Form

Fellow's Name: _____

Lab/Branch: _____

Fellowship No: _____

Effective Date: _____

Prepared By: _____

Note to ARC: Submit the original package with documents in a folder with the ~~CCR~~ DCTD route slip attached to the front cover ~~and the BMS attached to the left inside of folder.~~

Complete	N/A	Required Form/Document (assemble package as follows)
1. ☐		~~CCR~~ DCTD Routeslip; (make note of the conversion from Summer CRTA to SPV in the executive summary box)
2. ☐		~~BMS Report - *ARC will complete:* (change to SPV - add footnote of time spent as SIP)~~
3. ☐		FPS Generated Termination Notice – ARC Generates
4. ☐		NIH 590 Special Volunteer and Guest Researcher Assignment - above section 1 include CAN # and HNC #
5. ☐		NIH 590-2 Special Volunteer Agreement - must be signed by parent/guardian
6. Reminder		If fellow is overpaid (see FPS term notice), provide check from fellow

Sample Award Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES

National Institutes of Health
National Cancer Institute

April 23, 2010
SIP Name
SIP Address

Dear SIP Name:

Congratulations on your acceptance into the Werner H. Kirsten Student Intern Program (SIP). To serve the summer portion of your internship you are receiving a Cancer Research Training Award (CRTA) from the National Cancer Institute (NCI). Your internship is in the Lab; your sponsor is Dr. Sponsor Name; and your daily mentor is Dr. Mentor Name. Your initial CRTA appointment is for an eight week period and your stipend will be approximately $1775 per month. For the school-year portion of your internship, you will be appointed as a Special Volunteer without a stipend.

Please contact Lab Administrator Name within the Lab on Lab Administrator Phone to establish a start date that is convenient for you and your mentor. If you plan to take a vacation during the eight week period, you are expected to discuss this with your mentor in advance and to arrange to make up the missed time.

There are administrative requirements you will need to complete before starting in the lab. The following items **MUST** be completed prior to the start of your internship; some of the items may require information from your physician or bank, so plan ahead to meet the deadlines:

1. The documents listed below must be completed and/or signed and returned to Lab Administrator Name no later than **May 14th**. Please return all of the forms at the same time. The forms can be hand delivered or mailed using the enclosed return envelope.
    a. *Agreement to Provisions* signed by the intern and the parent/guardian after reading the attached *Provisions*.
    b. *SF-3881 ACH Payment* form completed by the intern and/or by a representative from the intern's bank. This form authorizes mandatory direct deposit of the intern's stipend to the financial institution of their choice.
    c. *SF-181Ethnicity and Race Identification* form completed by the intern.
    d. *SF-256 Self Identification of Handicap* form completed by the intern.
    e. *Sexual Harassment Certification* signed by the parent/guardian after reading the attached policy on sexual harassment and discussing with the intern.
    f. A copy of your health insurance card as evidence of health insurance; or indicate that you will need to get health insurance on the *Agreement to Provisions* as outlined in the CRTA *Provisions*.
    g. *HHS 745 ID Badge Request Form with Parental Consent Attachment* with section A of form completed by intern and signed/dated (box #15/#16) on page 1. *Parental Consent Attachment* completed and signed by parent/guardian.
    h. *Parental Consent Letter* to be signed and dated by parent/guardian of intern.
    i. *SF-93Report of Medical History* must be completed by the intern and signed (in box 24b.). The form **does not** need to be signed by a Physician.
    j. *Documentation of Immunizations* completed and signed by a Physician, **OR**, in place of the form you can provide a copy of an original vaccination record.
    k. *OHS Employee Information Form* completed by the intern.

l. *Acknowledgement of Receipt of Notice of Privacy Practices* must be signed by the parent/guardian after reading the attached *Notice of Privacy Practices*. Only return the signature page.
m. *Authorization and Medical Release for a Minor at the NCI-Frederick* must be signed by parent/guardian.

2. You must attend **mandatory safety training May 19th** from 7:30 a.m. to 3:30 p.m., in the Conference Room of Building 426, on the NCI-Frederick campus. There will be a rain or shine tour of the campus following training, so wear comfortable clothes and be prepared for the possibility of rain.

3. On the day of your appointment please report to Lab Building Lab Room and bring a photo ID (State drivers license, State issued photo ID, passport, etc.). Also, if you plan to park your vehicle on a daily basis, please bring your vehicle registration and auto insurance card with you to obtain vehicle decals. If you will be driving a vehicle that is in someone else's name, please bring a letter from the person stating that you have permission to drive their vehicle.

We look forward to your participation in the Werner H. Kirsten Student Intern Program and hope you find it to be a rewarding experience. If you have any questions about your SIP appointment contact Lab Administrator Name.

Sincerely,

Preparer of Package

SIP Return Mail Checklist

Items must be completed/and or signed and returned by May 14, 2010.

☐ **Agreement to Provisions**
- ☐-Signed by intern and parent/guardian
- ☐-Copy of health insurance card; OR
- ☐-Need health insurance

☐ **SF-3881 ACH Payment (for Direct Deposit of Stipend)**
- ☐-Completed and signed by bank representative

☐ **SF-181 Ethnicity and Race Identification**
- ☐-Completed by intern

☐ **SF-256 Self Identification of Handicap**
- ☐-Completed by intern

☐ **Sexual Harassment Certification**
- ☐-Signed by parent/guardian

☐ **HHS 745 ID Badge Request Form with Parental Consent Attachment**
- ☐-Section A completed
- ☐-Signed and Dated by intern (box #15 & #16)
- ☐-Parental Consent Attachment completed and signed by parent/guardian

☐ **Parental Consent Letter**
- ☐-Signed by parent/guardian

☐ **SF-93 Report of Medical History**
- ☐-Completed and signed by intern (NOTE: Does not need Physician's signature)

☐ **Documentation of Immunizations**
- ☐ -Signed by Physician; OR
- ☐-Substituted original vaccination record for form

☐ **OHS Employee Information Form**
- ☐-Completed by intern

☐ **Acknowledgement of Receipt of Notice of Privacy Practices**
- ☐-Signed by parent/guardian and return signature page ONLY

☐ **Authorization and Medical Release for a Minor at the NCI-Frederick**
- ☐-Signed by parent/guardian (under part 2)

Please be advised we need ALL of the forms and information completed CORRECTLY or the student's start date may be delayed. THANK YOU!

3/12/01 - NATIONAL CANCER INSTITUTE
CANCER RESEARCH TRAINING AWARD (CRTA)
1/27/10 - MODIFIED FOR PARTICIPANTS IN THE WERNER H. KIRSTEN STUDENT INTERN PROGRAM (SIP)

Provisions

A. Qualifications

1. Cancer Research Training Awards are for U.S. citizens or resident aliens.

2. For predoctoral students, official documentation that the student is in good academic standing (cumulative grade-point average included) and is enrolled at least half time in high school is needed.

3. Applicants must be at least 16 years of age. For individuals under 18 years of age, parental consent is required.

4. Prior to the start date of their CRTA appointment, CRTA fellows are required to visit the Occupational Health Services office located at the NCI-Frederick for a general health assessment.

B. Awards

1. The specific award period and stipend amount are stated in the attached Notification Letter. Fellowships are for eight weeks during the summer break between the student's junior and senior years of high school. Fellowship training is on a full-time basis.

2. Interns are strongly urged to take vacations prior to or after internships to permit continuous training. If, upon selection, interns are aware of planned vacation time, they should inform their SIP mentor and administrative lab contact as promptly as possible.

3. Upon completion of the summer CRTA portion of the SIP and at the beginning of their senior year of high school, the student will then be converted to the Special Volunteer Program for the remainder of their internship. Students will not be compensated for their service during the school year. However, they will receive credits toward their Maryland State Diploma.

4. In addition to these CRTA provisions, SIP award information is outlined in the SIP Online Application.

C. Stipends and Benefits

1. CRTA stipends are paid from NCI funds. Upon notification of the activation, the first stipend check will be issued at the end of the first month in which training began. Stipends are paid in arrears and electronically transferred by the Treasury Department (usually received by the 1st working day of each month) for direct deposit to the student's designated financial institution.

2. Fellows must be covered by adequate health insurance. Fellows covered under a plan, such as a parent or guardian's health insurance plan, should submit a copy of their health insurance card as evidence of insurance.

   For fellows that do not have health insurance coverage, an approved plan is available through the Foundation for Advanced Education in the Sciences (FAES) and enrollment must be completed within

30 days from arrival at NIH. Enrollment becomes effective on the date all forms are completed by both FAES and the fellow. NCI pays FAES for individual low option insurance in addition to the regular stipend paid to the fellow. If the fellow desires the FAES high option insurance, the difference between low and high option coverage will be withheld from the stipend.

For fellows enrolled in a private plan in their name, reimbursement to the fellow will be based on FAES low option coverage. Sufficient documentation verifying health insurance coverage and documenting health insurance costs are required for a non-FAES policy.

3. Tort Claims: It is the opinion of the DHHS Office of the General Counsel (OGC) that fellows would be eligible for coverage under the Federal Tort Claims Act (FTCA) (28 U.S.C. 2671 et seq.) for damages or injuries that arise from actions occurring within the scope of their assignment and while under the direct supervision of a Federal employee. The OGC opines that fellows working under the close preceptorship of NIH employees would be considered employees for all purposes relating to liability. However, the ultimate decision on issues of liability is made by the courts on a case-by-case basis. Should claims arise from the actions of CRTA fellows acting within the scope of their assignments, NIH would ask that they be defended by the Department of Justice as if they were Federal employees. Clinical procedures, therefore, should be performed under the direct supervision of an NCI attending physician in an NCI facility. Designated physicians must acquire patient-care privileges and credentialing as required.

4. While at NIH, allowances to attend scientific meetings, field research visits, or for training directly related to the purpose of the fellowship, may be authorized. All requests must be initiated by the sponsor and must be submitted to the Administrative Office for approval in advance of the meeting/training and must be carried out in accordance with government regulations.

D. Deductions and Income Taxes

1. Cancer Research Training Awardees are not Government employees, and are, therefore, not eligible to participate in the Federal Employees Retirement System. Since fellows receive awards for training, neither Social Security nor Medicare is deducted from stipends.

   Definitive determinations regarding Social Security obligations and coverage must be made by the Internal Revenue Service (IRS). Nevertheless, it is the opinion of the NIH Legal Advisor that Fellows would not be considered self-employed for purposes of Social Security Act coverage, and therefore need not make Social Security or Medicare payments on their own behalf.

   Some helpful tax advice and information on IRA accounts may be found at the NIH Postdoctoral/Clinical Fellows Committee FELCOM web site: http://www.training.nih.gov/handbook/taxes.html

2. Research fellowship training awards are subject to federal, state and local incomes taxes. Interpretation and implementation of the tax laws is the domain of the IRS and the courts. Awardees should consult their local IRS office about the applicability of the current tax code changes, taxability of fellowship stipends, and the proper steps to be taken regarding their tax obligations. Publication 17 is a useful resource for tax preparation guidance, and may be accessed through the IRS Home Page: http://www.irs.gov/

   a. Fellows are required to file quarterly estimated federal and state income tax returns since no taxes are withheld from their stipends. Information on estimated tax procedures, forms and due dates can be found at http://www.irs.gov/publications/p505/index.html

b. The Office of Financial Management, Fellowship Payroll Office, annually prepares CRTA 1099G tax forms--the stipend is considered a taxable grant award by IRS--and sends appropriate income information to the IRS and to fellows at their home address of record.

E. Excused Absence

1. Paid Absence - Since fellows are not employees, they do not earn annual or sick leave. They are, however, excused on federal holidays. At the discretion of the sponsor, fellows may be excused for reasonable cause (such as short-term personal emergencies, ill health, vacation, and personal relaxation). An excused absence for the delivery of a baby or adoption may be granted with flexibility determined by the sponsor. Although stipend and health insurance coverage will continue for excused paid absences, the period of the fellowship award is not extended due to lost time. SIP students should also review the *Program Information* section of the SIP application for additional information on their responsibilities with regard to absence from the lab.

2. Unpaid Absence - A break in the award without stipend may be approved by the sponsor with concurrence from respective Lab/Branch/Office Chief. A fellow will be personally responsible for payment for health insurance coverage for any month in which they are in absence without stipend on the first day of the month.

F. Outside Work

Approval of outside employment is at the discretion of the sponsor and the same guidelines as for NIH employees apply, provided the fellow is able to meet a minimum of 40 hours per week on his/her fellowship assignment. Fellows should submit a memorandum requesting approval of outside work through Division channels with final approval by the Division Director and/or Deputy Ethics Counselor.

G. Publications and Patents

The publication and patenting of scientific discoveries by fellows are governed by the same policies as for other scientists employed or in training at NIH. Fellows must not provide outside organizations or individuals with information that could form the basis of intellectual property rights for the Government.

H. Termination of Award for Cause

Awards may be revoked in whole or in part by the Division Director in collaboration with the Executive Officer for the respective Intramural or Extramural Research Program, acting upon specific requests by the sponsor or Laboratory/Branch Chief, provided that the revocation does not include repayment of funds that participants have already earned. Awards may be terminated prior to their normal expiration date for serious personal or scientific misconduct. Awards may also be terminated based on a finding that the Fellow has failed to comply with the terms and conditions of the award or to carry out the purpose for which it was made. Any termination proposal must provide an opportunity for the Fellow to make reply before a decision is rendered. Under this appointment, Merit Systems Protection Board appeal rights are not conferred and do not apply since trainees are not considered Government employees.

The Division must notify OFM immediately when an award is terminated for cause, to avoid the possibility of overpayment.

For individual under 18 years of age, parental consent must be indicated on the Agreement to Provisions.

*****

NIH is an Equal Opportunity Employer

Applicants will receive consideration without regard to race, color, sex, national origin, age, religion, or disability. U.S. citizenship or permanent residency status is required.

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NATIONAL CANCER INSTITUTE
CANCER RESEARCH TRAINING AWARD
MODIFIED FOR PARTICIPANTS IN THE WERNER H. KIRSTEN STUDENT INTERN PROGRAM (SIP)

Agreement to Provisions

In accepting this training award, I certify that I have read the program provisions and agree to comply with the terms outlined:

A. Qualifications (check one box for each of the 2 questions):

1. ☐ I am a U.S. citizen, **OR**;
   ☐ I am a Resident Alien and I am enclosing a copy of my Alien Registration (green or pink) card.

2. ☐ I meet the degree requirements and am enclosing a copy of my diploma or certification by the Dean or Registrar of that degree, **OR**;
   ☒ I am a student and I provided official documentation that I am enrolled in high school as part of my SIP application.

B. Stipends and Benefits:

I understand that I must have adequate health insurance coverage while participating in the SIP program, either through a private plan or through the Foundation for Advanced Education in the Sciences, Inc. (FAES).

Choose one of the following options:

☐ I am covered under a health insurance plan issued to someone else, such as a parent or guardian, and I am attaching a copy of my health insurance card,

OR;

☐ I am not currently covered under a health insurance plan and will obtain health insurance through FAES or another private provider. I understand that NCI will pay for my FAES health insurance coverage or will reimburse me for coverage under a private plan, for the CRTA (paid summer) portion of my SIP appointment. Payment or reimbursement from NCI will be limited to the cost of FAES low option coverage. Documentation verifying health insurance coverage and costs will be provided for a non-FAES policy. Further, I understand that I will be responsible to maintain and pay for the health insurance coverage during the Special Volunteer portion of my SIP appointment. I will provide a copy of my health insurance card as proof of coverage at the start of my Special Volunteer appointment.

I will immediately notify the Laboratory/Branch Office of any change in my status and I also agree to reimburse the U.S. Government for any days (other than excused absences) for which I have already been paid, but will not be in training. I understand that knowingly converting any overpayment for my use may be a violation of 18 United States Code §641.

I will seek advance approval for travel to attend scientific meetings, to do field research visits, or for training directly related to the purpose of my CRTA. I understand that the authorization of such allowances must be in accordance with government regulations.

C. Deductions:

I understand I am not eligible for coverage under the Federal Employees Retirement System (FERS) and deductions for this program, Social Security, and Medicare will not be made from my stipend.

I understand my fellowship award is subject to federal, state and local income taxes. As required, I will file quarterly estimated returns with the appropriate agencies.

I will notify my respective Lab/Branch/Office of a change in my home address of record so that the income information contained in the 1099G can be forwarded to me for annual tax reporting.

D. Leave of Absence and Outside Work:

I will seek approval from my sponsor for any excused leave of absence, and other appropriate officials to engage in outside employment.

E. Publications and Patents:

I will seek advice from my preceptor and request clearance for any publication resulting from my Fellowship in compliance with NIH's publication policies.

I agree not to disclose any confidential or proprietary information to which I may have access without the prior approval of my sponsor and Lab/Branch Chief.

I will be bound by all provisions of Executive Order 10096, and any orders, rules, regulations or the like issued thereunder wherein NIH determines the rights of the Government and the Fellow in and to inventions conceived or actually reduced to practice during the period of the Fellowship. Furthermore, I will promptly disclose to my sponsor and other appropriate officials all inventions that are conceived or first reduced to practice during the term of my Fellowship at NIH, and will sign and execute all papers necessary to convey to the Government the rights to which the Government is entitled in accordance with any determination made under the provisions of Executive Order 10096.

F. Other Administrative Requirements:

While on the premises of NIH, I will conform to all applicable administrative instructions and requirements of NIH and the Department of Health and Human Services, including all regulations and procedures concerning conduct, safety, and animal care. I am aware that my award may be terminated prior to the normal expiration date based on serious personal or scientific misconduct. Also, my award may be terminated based on my failure to comply with the terms and conditions of the award.

I have been advised of the requirement for a general health assessment to be conducted by the NCI-Frederick Occupational Health Service's related to fitness for duty while participating in the training assignment.

Signature of Fellow	Date
Signature of Parent or Guardian (if under 18)	Date

ACH VENDOR/MISCELLANEOUS PAYMENT ENROLLMENT FORM

This form is used for Automated Clearing House (ACH) payments with an addendum record that contains payment-related information processed through the Vendor Express Program. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

PRIVACY ACT STATEMENT

The following information is provided to comply with the Privacy Act of 1974 (P.L. 93-579). All information collected on this form is required under the provisions of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data, by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.

AGENCY INFORMATION

FEDERAL PROGRAM AGENCY: National Institutes of Health, Office of Financial Management		
AGENCY IDENTIFIER: NIH Treasury 303	AGENCY LOCATION CODE (ALC): 75-08-0031 or 75-08-0040	ACH FORMAT: ☐ CCD+ ☐ CTX ☐ CTP
ADDRESS: 31 Center Drive, MSC 2045, Building 31, Room B1B04		
Bethesda, MD 20892-2045		
CONTACT PERSON NAME: Sandy Thrasher	TELEPHONE NUMBER: (301) 496-5635 FAX: (301) 402-1025	
ADDITIONAL INFORMATION: Original signature must be on file		

PAYEE/COMPANY INFORMATION

NAME:	SSN NO. OR TAXPAYER ID NO.:
ADDRESS:	
CONTACT PERSON NAME:	TELEPHONE NUMBER:

FINANCIAL INSTITUTION INFORMATION

NAME:	
ADDRESS:	
ACH COORDINATOR NAME:	TELEPHONE NUMBER:
NINE-DIGIT ROUTING TRANMIT NUMBER:	
DEPOSITOR ACCOUNT TITLE:	
DEPOSITOR ACCOUNT NUMBER:	LOCKBOX NUMBER:
TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS ☐ LOCKBOX	
SIGNATURE AND TITLE OF AUTHORIZED OFFICIAL: (Could be the same as ACH Coordinator)	TELEPHONE NUMBER:

U.S. Office of Personnel Management
Guide to Personnel Data Standards

ETHNICITY AND RACE IDENTIFICATION

(Please read the Privacy Act Statement and instructions before completing form.)

Name (Last, First, Middle Initial)	Social Security Number	Birthdate (Month and Year)

Agency Use Only

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

D **Question 1. Are You Hispanic or Latino?** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ Yes ☐ No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

	RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
A	☐ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
B	☐ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
C	☐ Black or African American	A person having origins in any of the black racial groups of Africa.
B	☐ Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
E	☐ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

SELF-IDENTIFICATION OF HANDICAP

(See instructions and Privacy Act information on reverse)

Last Name, First Name, Middle Initial	Birth Date *(Mo./Yr.)*	Social Security Number	ENTER CODE HERE →

DEFINITION OF A HANDICAP: A person is handicapped if he or she has a physical or mental impairment which substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. Those handicaps that are to be reported are listed below (codes in bold numbers 13 through 94). In the case of multiple impairments, choose the code which describes the impairment that would result in the most substantial limitation.

TO THE EMPLOYEE: Self-identification of handicap status is essential for effective data collection and analysis. The information you provide will be used for statistical purposes only and will not in any way affect you individually. While self-identification is voluntary, your cooperation in providing accurate information is critical.

01 I do not wish to identify my handicap status. *(Please read the employee note above and the reverse side of this form before using this code.)* (Note: Your personnel officer may use this code if, in his or her judgment, you used an incorrect code.)

05 I do not have a handicap.

06 I have a handicap but it is not listed below.

SPEECH IMPAIRMENTS

13 Severe speech malfunction or inability to speak; hearing is normal *(Examples: defects of articulation [unclear language sounds]; stuttering; aphasia [impaired language function]; laryngectomy [removal of the "voice box"])*

HEARING IMPAIRMENTS

15 Hard of hearing *(Total deafness in one ear or inability to hear ordinary conversation, correctable with a hearing aid)*

16 Total deafness in both ears, with understandable speech

17 Total deafness in both ears, and unable to speak clearly

VISION IMPAIRMENTS

22 Ability to read ordinary size print with glasses, but with loss of peripheral (side) vision *(Restriction of the visual field to the extent that mobility is affected--"Tunnel vision")*

23 Inability to read ordinary size print, not correctable by glasses *(Can read oversized print or use assisting devices such as glass or projector modifier)*

24 Blind in one eye

25 Blind in both eyes *(No usable vision, but may have some light perception)*

MISSING EXTREMITIES

27 One hand
28 One arm
29 One foot
32 One leg
33 Both hands or arms
34 Both feet or legs
35 One hand or arm *and* one foot or leg
36 One hand or arm *and* both feet or legs
37 Both hands or arms *and* one foot or leg
38 Both hands or arms *and* both feet or legs

NONPARALYTIC ORTHOPEDIC IMPAIRMENTS

(Because of chronic pain, stiffness, or weakness in bones or joints, there is some loss of ability to move or use a part or parts of the body.)

44 One or both hands
45 One or both feet
46 One or both arms
47 One or both legs
48 Hip or pelvis
49 Back
57 Any combination of two or more parts of the body

PARTIAL PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is some loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

61 One hand
62 One arm, any part
63 One leg, any part
64 Both hands
65 Both legs, any part
66 Both arms, any part
67 One side of body, including one arm and one leg
68 Three or more major parts of the body *(arms and legs)*

COMPLETE PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is a complete loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

70 One hand
71 Both hands
72 One arm
73 Both arms
74 One leg
75 Both legs
76 Lower half of body, including legs
77 One side of body, including one arm and one leg
78 Three or more major parts of the body *(arms and legs)*

OTHER IMPAIRMENTS

80 Heart disease with no restriction or limitation of activity *(History of heart problems with complete recovery)*

81 Heart disease with restriction or limitation of activity

82 Convulsive disorder *(e.g., epilepsy)*

83 Blood diseases *(e.g., sickle cell anemia, leukemia, hemophilia)*

84 Diabetes

86 Pulmonary or respiratory disorders *(e.g., tuberculosis, emphysema, asthma)*

87 Kidney dysfunctioning *(e.g., if dialysis [Use of an artificial kidney machine] is required)*

88 Cancer--a history of cancer with complete recovery

89 Cancer--undergoing surgical and/or medical treatment

90 Mental retardation *(A chronic and lifelong condition involving a limited ability to learn, to be educated, and to be trained for useful productive employment as certified by a State Vocational Rehabilitation agency under section 213.3102(t) of Schedule A)*

91 Mental or emotional illness *(A history of treatment for mental or emotional problems)*

92 Severe distortion of limbs and/or spine *(e.g., dwarfism, kyphosis [severe distortion of back])*

93 Disfigurement of face, hands, or feet *(e.g., distortion of features on skin, such as those caused by burns, gunshot injuries, and birth defects [gross facial birthmarks, club feet, etc.])*

94 Learning disability *(A disorder in one or more of the processes involved in understanding, perceiving, or using language or concepts [spoken or written]; e.g., dyslexia)*

The Rehabilitation Act of 1973 (P.L. 93-112) requires each agency in the Executive branch of the Federal Government to establish definite programs that will facilitate the hiring, placement, and advancement of handicapped individuals. The best means of determining agency progress in this respect is through the production of reports at certain intervals showing such things as the number of handicapped employees hired, promoted, trained, or reassigned over a given time period; the percentage of handicapped employees in the work force and in various grades and occupations; etc. Such reports bring to the attention of agency top management, the Office of Personnel Management (OPM), and the Congress deficiencies within specific agencies or the Federal Government as a whole in the hiring, placement, and advancement of handicapped individuals and, therefore, are the essential first step in improving these conditions and consequently meeting the requirements of the Rehabilitation Act.

The handicap data collected on employees will be used only in the production of reports such as those previously mentioned and not for any purpose that will affect them individually. The only exception to this rule is that the records may be used for selective placement purposes and selecting special populations for mailing of voluntary personnel research surveys. In addition, every precaution will be taken to ensure that the information provided by each employee is kept in the strictest confidence and is known only to the one or two individuals in the agency Personnel Office who obtain and record the information for entry into the agency's and OPM's personnel systems. You should also be aware that participation in the handicap reporting system is entirely voluntary, **with the exception of employees appointed under Schedule A, section 213.3102(t) (Mental Retardation); Schedule A, section 213.3102(u) (Severely Physically Handicapped); and Schedule B, section 213.3202(k) (Mentally Restored).** These employees will be requested to identify their handicap status and if they decline to do so, their correct handicap code will be obtained from medical documentation used to support their appointment. No other employees will be required to identify their handicap status if they feel for any reason it is not in their best interest to have this information officially recorded outside of medical records. We request only that anyone not wishing to have this information entered in the agency's and OPM's personnel systems indicate this to their Personnel Office, rather than intentionally miscoding themselves, since false responses will seriously damage the statistical value of the reporting system.

[In those instances where the employee is or was hired under Schedule A, section 213.3102(t) (Mental Retardation), the Personnel Director or his/her disignee (a Vocational Rehabilitation Counselor may also be helpful) will assist the individual in completing this form and ensure that the employee fully understands the meaning of the form and the options available to him/her, as noted above.]

Employees will be given every opportunity to ensure that the handicap code carried in their agency's and OPM's personnel systems is accurate and is kept current. They may exercise this opportunity by asking their Personnel Officer to see a printout of the code and definition from their record, by notifying Personnel any time their handicap status changes, and by initiating action in either of these cases to have the necessary changes made to their records. The code carried on employees in their agency's system will be identical to that carried in OPM's system, and any change to the agency records will result in the same change being made to OPM's records.

PRIVACY ACT STATEMENT

Collection of the requested information is authorized by the Rehabilitation Act of 1973 (P.L. 93-112). The information you furnish will be used for the purpose of producing statistical reports to show agency progress in hiring, placement, and advancement of handicapped individuals and to locate individuals for voluntary participation in surveys. The reports will be used to inform agency top management, the Office of Personnel Management (OPM), the Congress, and the public of the status of programs for employment of the handicapped. All such reports will be in the form of aggregate totals and will not identify you in any way as an individual.

Solicitation of your Social Security Number (SSN) is authorized by Executive Order 9397, which requires agencies to use the SSN as the means for identifying individuals in personnel information systems. Your SSN will only be used to ensure that your correct handicap code is recorded along with the other employee information that your agency and OPM maintain on you. Furnishing your SSN or any other of the requested data for this collection effort is voluntary and failure to do so will have no effect on you. It should be noted, however, that where individuals decline to furnish their SSN, the SSN will be obtained from other records in order to ensure accurate and complete data.

Employees appointed under Schedule A, section 213.3102(t) (Mental Retardation), Schedule A, section 213.3102(u) (Severely Physically Handicapped), or Schedule B, section 213.3202(k) (Mentally Restored) are requested to furnish an accurate handicap code, but failure to do so will have no effect on them. Where employees hired under one of these appointments fail to disclose their handicap, however, the appropriate code will be determined from the employee's existing records or medical documentation submitted to justify the appointment.

Policy Statement on the Prevention of Sexual Harassment

To: All NIH Employees

From: Director

Subject: Policy Statement on the Prevention of Sexual Harassment

The policy of the National Institutes of Health is that sexual harassment is unacceptable conduct and will not be tolerated. Sexual harassment is a form of sex discrimination and is an "unlawful employment practice" under Title VII of the Civil Rights Act of 1964, as amended. It is also prohibited under the Department of Health and Human Services Standards of Conduct that specify certain types of sexually-related misconduct as "unbecoming an agency employee."

Sexual harassment is defined in law and regulation as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Sexual harassment can occur when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment; (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting the individual; or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Preventing sexual harassment is the responsibility of every member of the NIH. Any employee who believes he or she is a victim of sexual harassment should report the allegation(s) to the appropriate agency official, or contact the Office of Equal Opportunity and Diversity Management (OEODM), who will provide assistance and guidance. It is the responsibility of management to investigate allegations of sexual harassment in a confidential manner and take necessary action to ensure that these allegations are addressed swiftly, fairly, and effectively. Additionally, managers and supervisors must be aware of what constitutes sexual harassment in order to explain the sanctions for violations, and must provide regular training sessions for all employees in the prevention of sexual harassment. To further emphasize the preventive requirement, an online training module for the Prevention of Sexual Harassment is available for all personnel at http://eeotraining.nih.gov.

I count on each of you to do your part. If you have any questions or concerns regarding this policy, please contact the OEODM at (301) 496-1551, TTY (301) 496-9755, or the Federal Relay Service at 1-800-877-8339 (Voice/TTY/ACSII/Spanish).

/s/

Elias A. Zerhouni, M.D.

FOLLOW THE "PLATINUM RULE" ...

Do unto others as they would have you do unto them.

DO NOT ENGAGE IN ...

- Telling sexual jokes or stories
- Referring to someone inappropriately, e.g., "hunk," "babe," etc.
- Explicit comments about someone's clothing, anatomy, or appearance
- Sending e-mails that are sexual in nature (e.g., jokes, photos)
- Letters, telephone calls, magazines, pictures, and objects of a sexual nature or content
- Deliberately touching, brushing, cornering, pinching, or leaning over a person
- Suggestive looks, comments, gestures, or whistles
- Discussing actual or imagined sexual activities
- Crude, gross, or sexually profane language
- Unwelcome pressure for dates or sexual favors
- Giving inappropriate or unwelcome gifts
- Displaying sexually suggestive visuals
- Making suggestive facial expressions, hand, or body gestures
- Touching or rubbing oneself sexually around another person
- Actual or attempted rape or sexual assault

IF YOU BELIEVE YOU ARE BEING HARASSED ON ANY EEO BASIS, act promptly. Make it clear to the individual that the conduct is unwelcome and must stop.

Keep a record of any incidents such as dates, times, places, your responses, and witnesses.

Tell your supervisor about the conduct. If your supervisor is the alleged harasser, tell a higher-level supervisor.

For assistance, contact the NIH Office of Equal Opportunity and Diversity Management (OEODM) at 301-496-1551.

MANAGERIAL/SUPERVISORY RESPONSIBILITIES

Managers and supervisors are responsible for being aware of what constitutes sexual harassment; how to recognize it; how to prevent it from occurring; and taking corrective action, including disciplinary action, as needed. Failure to do so places the management official in a position of personal liability if the allegation is later proven to have merit.

EQUAL EMPLOYMENT OPPORTUNITY

Sexual Harassment

Office of Equal Opportunity & Diversity Management

Tel: 301.496.1551
TTY: 301.480.3122

January 2004

DEFINITION OF SEXUAL HARASSMENT

Title VII of the Civil Rights Act of 1964 prohibits discrimination based on sex. The Supreme Court has made it clear that sexual harassment is a form of unlawful sex discrimination.

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when submission to or rejection of this conduct, explicitly or implicitly:

- Affects a term or condition of an individual's employment,
- Interferes with an individual's work performance, or
- Creates an intimidating, hostile or offensive work environment.

It is important to note that the victim, as well as the harasser, may be of either gender. Also, the victim and harasser do not have to be opposite sexes.

Harassment, when characterized as a hostile work environment, is also prohibited under the other EEO bases of race, color, national origin, religion, disability, age, and reprisal.

TYPES OF SEXUAL HARASSMENT

QUID PRO QUO

"This for That"

Quid Pro Quo harassment involves granting or denying employment benefits based on an individual's response to sexual advances.

The harasser has (or is perceived to have) management authority over the individual.

The harasser undertook or recommended a tangible employment action.

The harasser's action is based on the individual's response to the unwelcome sexual advances or demands.

Quid Pro Quo harassment occurs whether or not the individual submitted to or rejected the advances.

Quid Pro Quo harassment occurs even if the individual rejects the unwelcome sexual advances and suffers no adverse job consequences.

TYPES OF SEXUAL HARASSMENT

HOSTILE WORK ENVIRONMENT

Hostile work environment harassment is conduct that unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive work environment.

This type of harassment can be committed by a supervisor, co-worker, or non-employee.

A tangible employment action does not have to be involved.

Frequency and severity of the conduct are key factors in determining whether EEO law has been violated.

A "reasonable person" standard governs. Harassment is defined by the impact of a person's conduct, not by his/her intentions.

Severe psychological harm is not necessary to establish a violation.

The victim does not have to be the person harassed, but can be anyone impacted by offensive conduct directed at others.

Werner H. Kirsten Student Intern Program at the

NCI at Frederick

Sexual Harassment Certification

Student's Name:_____

SEXUAL HARASSMENT CERTIFICATION

Attached is a memorandum regarding the NIH Policy Statement on Sexual Harassment. Also attached are the pages (2) of a tri-fold published by the Office of Equal Opportunity & Diversity Management, NIH, on Sexual Harassment. Please certify that you and the student applicant have read and understand this policy by signing below.

_____

Parent/Guardian Signature and Date

Applicant Instructions for Completing Form HHS-745, "HHS ID Badge Request"

Section A collects identifying information about Applicants needed to issue an HHS ID Badge. In some Federal agencies, Sponsors or other authorized officials will complete this section for Applicants. If you are an Applicant and are asked to complete Section A, follow the instructions below.

Clearly print all information except for your signature.

Section A

1. Check the appropriate box to indicate why a new HHS ID Badge is being issued. If you check "Other," please indicate the reason in the space provided.
2. Enter your full legal name on the first line. If you have used other name(s), enter these names on the "Other Name(s) Used" line.
3. Enter your date of birth in mm/dd/yyyy format.
4. Enter your place of birth (city and state if born in the U.S. or city and country if foreign born).
5. Enter your Social Security Number (xxx-xx-xxxx).
6. Check whether you are a U.S. citizen. If you are not a U.S. citizen, enter the country where you are a citizen.
7. Enter your position title (include series and grade level).
8. Enter where you will be working. This could include the center, office, group, division, or institute. If you are a contractor Applicant, enter the organizational chain for the COTR's or Project Officer's division.
9. Enter the physical location (building and office) of your office, work area, or contract office.
10. Enter your work telephone number. If none, then list Contract Officer's, COTR's, or Project Officer's telephone number.
11. Enter your email address.

Contractors and others employed outside the Federal government, complete items 12 through 14.

12. Enter your company's name.
13. Enter your company's address.
14. Enter your company's telephone number.

All Applicants complete items 15 and 16.

15. Sign to authorize HHS to conduct the identity proofing/verification process and to certify that you understand that actions may be taken against you if you provide false information on this form.
16. Enter the date you signed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services (HHS) Identification (ID) Badge Request

(Other Federal Departments may call this type of ID badge a Personal Identity Verification [PIV] card)

HHS ID BADGE ISSUING FACILITY IDENTIFICATION NUMBER

Privacy Act Statement: The information on this form is collected by the Department of Health and Human Services (HHS) to issue you an identification badge called the HHS ID Badge. The purpose of the ID Badge is to help ensure the safety and security of government buildings, the people who work in them, and government computer systems. When you use your ID Badge an ID Badge system will verify that you are authorized to use government facilities. The system also will track and control the ID Badges that are issued. The authority to collect this information is 5 U.S.C. § 301; Presidential Memorandum on Upgrading Security at Federal Facilities, June 28, 1995; and Homeland Security Presidential Directive 12, August 27, 2004. The authority to request your Social Security number is Executive Order 9397. The disclosure of your Social Security number is voluntary, but it will assist in verifying your identity to process this application. The information on this form may be disclosed only with your written consent, except where permitted by the Privacy Act. The disclosures permitted by the Privacy Act include disclosure to: the Department of Justice, a court, or other government officials when the records are relevant and necessary to a law suit; the appropriate public authority (Federal, foreign, State, local, tribal, or otherwise) to enforce, investigate, or prosecute, when a record indicates a violation of law or regulation; a Member of Congress or congressional staff member at your written request; the National Archives and Records Administration for records management inspections; authorized Federal contractors, grantees, or volunteers who need access to the records to do agency work and who have agreed to comply with the Privacy Act; any source that has records an agency needs to decide whether to retain an employee, continue a security clearance, or agree to a contract, grant, license or benefit; Federal, State, or local agencies, entities, individuals, or foreign governments to enable an intelligence agency to carry out its responsibilities; the Office of Management and Budget to evaluate private relief legislation; and to other Federal agencies to notify them when your ID Badge is no longer valid. If you do not provide all of the requested information, we may deny you an ID Badge. Without an ID Badge, you will not have access to certain Federal facilities or systems. If using an ID Badge is a condition of your employment, not providing the information may prevent you from being able to work.

A. Applicant Information *(To be completed by Applicant, Sponsor, or Authorized Official)*

1. REASON FOR ISSUANCE ☐ New Application ☐ Renewal ☐ Lost ☐ Stolen ☐ Damaged ☐ Expired ☐ Other *(specify)*: _____

2. NAME *(Last, First, Middle)* | OTHER NAME(S) USED

3. DATE OF BIRTH *(mm/dd/yyyy)* | 4. PLACE OF BIRTH City | State or Province | Country

5. SOCIAL SECURITY NUMBER *(xxx-xx-xxxx)* | 6. U.S. CITIZEN ☐ Yes ☐ No *(specify citizenship)*: _____

7. POSITION TITLE: Student | 8. AGENCY/DIVISION: NCI

9. BUILDING/OFFICE ADDRESS: Fort Detrick | 10. WORK PHONE | 11. EMAIL

For Contractors, complete lines 12 through 14

12. ORGANIZATION/COMPANY NAME | 13. ADDRESS OF ORGANIZATION/COMPANY

14. TELEPHONE OF ORGANIZATION/COMPANY

To be completed by Applicant

I hereby authorize the release of information in this application to appropriate Federal agencies for the purposes of processing this application and verifying my identity. I also acknowledge that if I provide or assist in the provision of false information or non-verifiable information, and/or I purposely omit information, it could result in loss of access to HHS facilities and IT systems and in disciplinary action including removal from Federal service or a Federal contract, and I may be subject to prosecution under applicable Federal criminal and civil statutes.

15. APPLICANT SIGNATURE | 16. DATE *(mm/dd/yyyy)*

Parental Consent Attachment:

This form should be attached to the Badge Request Form and submitted as one document.
(If you are age 18 or above, please disregard this page)

Parental Consent: As the parent of the child named above, I certify that all of the information provided is accurate and complete. I have read and agree with the included privacy act statement, which states that the information contained in this form may be disclosed to proper authorities for the purposes of verifying my child's identity and determining my child's suitability to receive an NIH ID badge.

Parent / Guardian: Print Name _____

Parent / Guardian: Signature _____ Date: _____

Phone Number: _____

Parental Consent Letter
Use for Werner H. Kirsten Student Intern Program Appointment--Under 18 years old

Date
Dear Parent/Guardian Name:

On behalf of the Lab I am writing to inform you that SIP Name has offered to serve as a Werner H. Kirsten Student Intern Program/Summer Cancer Training Award Fellow in our organization. Your Daughter/Son will be working with me in my laboratory full time during the period of Start Date through End Date and During/After School? Hours? as a Special Volunteer during the period of Start Date through End Date doing some of the following tasks or projects:

(List a description of project(s) or tasks that is thorough but brief, using layman terms basic enough for most people to understand. Also briefly describe the environment-- noting if chemicals, specimen types, radiation, magnetic fields, etc are part of the environment.

During the time that SIP Name is working in our laboratory, She/He will be under my supervision at all times or under the supervision of Dr. Mentor Name. I or Dr. Mentor Name will instruct SIP Name on the proper safety procedures appropriate for our laboratory setting. He/She may also attend the NIH safety courses offered periodically as well.

I am writing to inform you, that as a minor under the age of 18, your Daughter/Son will need your approval before She/He can participate as a student with our research group. Additionally, all SIP/Summer Cancer Training Award Fellows are subject to a modified background screening. As such, your Daughter/Son will be required to be fingerprinted as part of this screening. Please sign and date below indicating your approval.

If you have any questions, my phone number is Phone Number.

Sincerely,

Sponsor Name

_____ _____

Signature of Parent or Guardian (Signature indicates your understanding and approval of daughter or son participation as noted above).

Date

SF-93 Report of Medical History
-completed and signed by intern (box 24)
DOES NOT need to be signed by your doctor

NO. OF ATTACHED SHEETS:

REPORT OF MEDICAL HISTORY

DATE OF EXAM

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT *(Last, first, middle)*	2. IDENTIFICATION NUMBER	3. GRADE
4a.. HOME STREEET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*	5. EXAMINING FACILITY	
4b. CITY / 4c. STATE / 4d. ZIP CODE		

6. PURPOSE OF EXAMINATION

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Use additional pages if necessary)*

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES *(Include insect bites/stings and common foods)*		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION	9. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED	

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
				Pain or pressure in chest				Loss of finger or toe			
Tuberculosis or positive TB test				Chronic cough				Painful or "trick" shoulder or elbow			
Blood in sputum or when coughing				Palpitation or pounding heart							
				Heart trouble				Recurrent back pain or any back injury			
Excessive bleeding after injury or dental work				High or low blood pressure							
				Cramps in your legs				"Trick" or locked knee			
Suicide attempt or plans				Frequent indigestion				Foot trouble			
Sleepwalking				Stomach, liver, or intestinal trouble				Nerve Injury			
Wear corrective lenses				Gall bladder trouble or gallstones				Paralysis *(including infantile)*			
Eye surgery to correct vision								Epilepsy or seizure			
Lack vision in either eye				Jaundice or hepatitis				Car, train, sea or air sickness			
Wear a hearing aid				Broken bones				Frequent trouble sleeping			
Stutter or stammer				Adverse reaction to medication				Depression of excessive worry			
Wear a brace or back support				Skin diseases				Loss of memory or amnesia			
Scarlet fever				Tumor, growth, cyst, cancer				Nervous trouble of any sort			
Rheumatic fever				Hernia				Periods of unconsciousness			
Swollen or painful joints				Hemorrhoids or rectal disease				Parent/sibling with diabetes, cancer, stroke or heart disease			
Frequent or severe headaches				Frequent or painful urination							
Dizziness or fainting spells				Bed wetting since age 12				X-ray or other radiation therapy			
Eye trouble				Kidney stone or blood in urine				Chemotherapy			
Hearing loss				Sugar or albumin in urine				Asbestos or toxic chemical exposure			
Recurrent ear infections				Sexually transmitted diseases							
Chronic or frequent colds				Recent gain or loss of weight				Plate, pin or rod in any bone			
Severe tooth or gum trouble				Eating disorder (anorexia bulimia, etc.)				Easy fatiguability			
Sinusitis								Been told to cut down or criticized for alcohol use			
Hay Fever or allergic rhinitis				Arthritis, Rheumatism, or Bursitis							
Head Injury								Used illegal substances			
Asthma				Thyroid trouble or goiter				Used tobacco			

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMO-GRAM
Treated for female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of.		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions.		
c. Inability to assume certain positions.		
d. Other medical reasons *(If yes, give reasons.)*		
13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*		
14. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		
15. Have you had, or have you been advised to have, any operation? *(If yes, describe and give age at which occurred.)*		
16. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*		
18. Have you ever been rejected for military service because of physical, mental or other reasons? (If *yes, give date and reason for rejection.)*		
19. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*		
20. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details.)*		
22. Have you ever been diagnosed with a learning disability? *(If yes, give type, where, and how diagnosed.)*		

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE

DOCUMENTATION OF IMMUNIZATIONS

Name_____ SSN_____
(Last 4 digits only)

Date of Birth:_____

1. **Tuberculosis**

Prior BCG Vaccine ____ Y ____ N
If Yes: Date_____
Date of last PPD_____Result_____
If Positive:
INH recommended ____ Y ____ N
Duration of treatment_____
Date of last chest x-ray_____Result_____
PPD placed ____ Y ____ N
5 T.U. 0.1 ml ID ____ L ____ R forearm
Mfg/Lot#_____
Results in mm_____ Date_____
Signature of reader_____
If positive:
Chest x-ray ordered ____ Y ____ N

2. **Tetanus Diptheria**
Date of last booster dose _____
Tetanus Diptheria given ____ Y ____ N

3. **Measles (Rubeola)**
Individuals born before January 1, 1951 are considered immune.
Date of immunizations (list 2)_____
One must have been given on or after January 1, 1980.
Or
*Documentation of positive titer*_____

Measles immunization given ____ Y ____ N
0.5 ml subcutaneous ____L ____R upper arm
Mfg/Lot #_____

4. **Chickenpox (Varicella)**
Date of immunization_____
Must have been given after 1994.
Or
*Documentation of positive titer*_____

5. **Hepatitis B**
Only necessary if working with patients, human blood or body fluids, or with the Hepatitis B virus.
If series has been started or completed, please provide:
Date of first dose_____
Date of second dose_____
Date of third dose_____

Health care provider's signature_____
Date_____

Documentation of Immunizations
-completed and signed by your doctor
YOU MAY replace form with original vaccination record

OHS Employee Information Form
-to be completed by intern

National Cancer Institute at Frederick
Occupational Health Services

Employee Information Form

SSN _____ Employee Number _____

Last Name _____ First _____ MI ___

Date of Birth _____ Sex *M / F*

Race (optional) *White* *Hispanic* *Black* *Asian* *Other*

Current Marital Status (optional) *Married* *Single* *Widow*

Divorced/Separated *Defacto*

Address _____

City _____ State _____ Zip _____

Home Phone # (_____) _____-_____

Company _____ Supervisor _____

Bldg/Room # _____ Job Title _____

Work Phone # (_____) _____-_____ Date of Hire _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____

Personal Physician Name _____

Address _____

Office Phone # (_____) _____-_____

OCCUPATIONAL HEALTH SERVICES
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Occupational Health Services is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Providing health information on the medical history form, interval history form, any other requested form or in person is voluntary. Information is used for purposes such as determining potential health hazards, differential diagnosis, and suitability for duty. Failure to provide certain health information may prohibit clinical staff from providing services relevant to that information such as denial of medication prescriptions and clearances for particular protective equipment, travel assignments, or fitness for duty. Providing incorrect information may be grounds for termination.

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: Occupational Health Services is required by the Labor and Employment Article, Title 9, Annotated Code of Maryland, The Maryland Worker's Compensation Act, and the Federal Employee's Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA), to receive and maintain personal information. Information submitted for Worker's Compensation claims is used to determine eligibility for and amount of benefits payable. Information may be provided back to the employer in order to verify statements or other relevant material. Information may be provided to providers of rehabilitation or return to work services. Information may be further disclosed as identified below. Disclosure of the social security number (SSN) to Occupational Health Services is mandatory. The SSN may be used for identification and for other purposes required or authorized by law. Failure to disclose the SSN may delay claim processing or payment of benefits. The last four numbers of the SSN are also requested when certain blood samples are placed in long term storage or tested under a unique identifier. Providing the last four numbers for this purpose is voluntary.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Occupational Health Services.

It is our policy to provide a substitute health care provider, authorized by Occupational Health Services to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

OCCUPATIONAL HEALTH SERVICES
NOTICE OF PRIVACY PRACTICES

Routine Information Practices
We may allow you to receive copies of laboratory results, surveillance or screening results, and routine test results such as blood pressures by signing a stamped duplicate copy in your medical chart. This stamped copy serves as your release and can only be obtained by you personally, unless other arrangements have been made.

We may inform you of an impending appointment by interdepartmental mail, e-mail, or a telephone message to your work telephone number of record. If you do not wish messages to be left at this address or number, please fill out our Request for Alternate Communication form. All telephone communications will request only that you contact Occupational Health Services.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.
Change of Ownership.
In the event that Occupational Health Services is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights
You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Occupational Health Services is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Occupational Health Services amend your protected health information. Please be advised, however, that Occupational Health Services is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Occupational Health Services.

You have a right to a paper copy of this Notice of Privacy.

Changes to this Notice of Privacy Practices
Occupational Health Services reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Occupational Health Services is required by law to comply with this Notice.

Occupational Health Services is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Carol Tobias by calling this office at 301-846-1096. If Carol Tobias is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature on the acknowledgement or like document, I provide Occupational Health Services with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Complaints
Complaints about your Privacy rights, or how Occupational Health Services has handled your health information should be directed to Carol Tobias by calling this office at 301-846-1096 If Carol Tobias is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 2003

Parent/Guardian Keep This Copy

Acknowledgement of Receipt of Notice
-must be signed by parent/guardian after reading the attached...
Notice of Privacy Practices
RETURN SIGNATURE PAGE ONLY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OCCUPATIONAL HEALTH SERVICES

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Occupational Health Services'** "NOTICE OF PRIVACY PRACTICES," revision date _ May 2004 _.

As required by the Privacy Regulations, **Occupational Health Services** will explain the "NOTICE OF PRIVACY PRACTICES" to my satisfaction, after I have completed reading it. I can contact the Privacy Officer noted in the "NOTICE OF PRIVACY PRACTICES" with any questions.

As required by the Privacy Regulations, I am aware that **Occupational Health Services** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

After having read the NOTICE OF PRIVACY PRACTICES, and understanding the practices and procedures Occupational Health Services has in place to protect my personal health information, I am hereby notified I have the right to request:

A "Request for Alternative Communications" of my Protected Health Information.
A "Request for Restriction" of my Protected Health Information.

I wish to object to the following in the "Notice of Privacy Practices:"

_____

"I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____ _____
Signature Date

_____
Print Name

_____
(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe)_____

_____

AUTHORIZATION AND MEDICAL RELEASE FOR A MINOR AT THE NCI-FREDERICK

PART 1:

_____ (name) will be working in the _____ (program) at the National Cancer Institute-Frederick (NCI-F).

Supervisor: _____ Supervisor Phone: _____ Minor's Work Location: _____

The minor's duties and responsibilities will be: (Description of Duties)

_____

_____

_____

Potential health and safety risks of the environment are:

____ Excessive Noise
____ Regular exposure to vibration
____ Corrosive, caustic, reactive chemicals
____ Heavy lifting/moving (up to 45-50 lbs.)
____ Machinery or moving vehicles
____ Regular exposure to inclement weather
____ Exposure to dusts (dander, feed, wood, metal)
____ Chemical carcinogens
____ Radioactive materials
____ Flammable solvents
____ Compressed gases
____ Blood/blood components from human &/or non-human primates
____ Infectious materials: Specify

_____

_____

_____

Minors will be informed of hazards associated with their project, will be trained in safe laboratory work practices, and will be supervised by an adult familiar with the project area.

Supervisor signature: _____ Date: _____

PART 2:

I hereby authorize my child (named above) to work at the NCI-Frederick as indicated herein. I authorize Occupational Health Services to provide, with his or her consent, any routine tests or physical examinations which are generally recognized as safe (including urine and blood analysis) and routine out-patient treatment (including emergency care) which may be necessary during normal working hours of the period of his or her employment at the NCI-Frederick, I understand that if my child has a serious condition or requires long term treatment or hospitalization, I shall be notified so that arrangements may be made to refer him or her to our private physician or clinic for such further care. I consent to the disclosure of his or her medical records to our private physician or clinic.

Signature: _____ Date: _____
Parent or Legal Guardian

Address: _____ Home Phone: _____

_____ Cell Phone: _____

EHS/OHS Office Use Only

Date received in EHS: _____ Reviewed by: _____
EHS Notes:

Date received in OHS: _____ Reviewed by: _____
OHS Notes:

Authorization and Medical Release for a Minor at the NCI-Frederick -completed and signed by parent/guardian (ONLY PART 2)

National Cancer Institute at Frederick
Serum Storage Program Informed Consent/Declination
Voluntary

It is the policy of the National Cancer Institute at Frederick (NCI-Frederick) to provide the option for a reference serum sample to be stored for employees whose job tasks may involve potential occupational exposure to infectious or other human illness-inducing materials.

All NCI-Frederick serum storage is done on a *voluntary* basis, and only for the benefit of the employee. Voluntarily obtained employee whole blood samples will be withdrawn by a qualified NCI-Frederick Occupational Health Services (OHS) clinician, in order to obtain an adequate quantity of the employee's serum for storage.

Employee serum becomes the property of the NCI-Frederick at the time of withdrawal and will be stored for a minimum of ten (10) years after employment termination. Stored serum will be tested only with the express written consent of the employee, or his/her authorized representative, to assist OHS in providing appropriate medical care should a suspected or confirmed occupational exposure occur, in accordance with the procedures outlined in the NCI-Frederick Environment, Health and Safety Operations and Compliance Manual (Section B-2).

****

I have read and understand the information above. I have had the opportunity to ask questions and have received satisfactory answers to any/all questions I've raised. I understand that my stored serum will be the property of the NCI-Frederick; and that my sera will be tested, only with my consent, and only as needed by NCI-Frederick's OHS, to assist with my medical treatment in the event of a suspected or confirmed occupational exposure.

_____ I voluntarily *consent* to withdrawal of my blood for serum storage.

_____ I voluntarily *decline* withdrawal of my blood for serum storage. I understand that I may change my mind at any time while employed in this or any other NCI-Frederick position in which the job tasks may involve potential occupational exposure to infectious or other human illness-inducing materials.

Employee's Name (Print):_____ ID#: _____D.O.B_____

Employee's Signature:_____ Date: _____

Parent/Guardian Signature:_____ Date _____

Witness' Name (Print): _____

Witness' Signature: _____ Date: _____

Phlebotomist's Signature: _____ Date: _____

_____ Initial Serum

_____ Termination Serum

_____ Declination

OHM ☐

Attach RSNM Here	Attach RSNM Here	Attach RSNM Here

CONFIDENTIAL MEDICAL RECORD

PS-Form No. 028
SOP ref. no. 5015
Prepared by: S. Fritz
Date prepared: 04 Oct 2005
Supersedes: New
Approved by:
Effective date: 11 Oct 2005

REQUEST FOR NCI-FREDERICK IDENTIFICATION CARD/CARDKEY FOR GOVERNMENT EMPLOYEES

EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)	NEW EMPLOYEES ONLY (TO BE COMPLETED BY REQUESTOR)
LAST NAME:	Date of Employment:
FIRST NAME:	Bldg: Room: Ext:
Social Security #:	☐ Permanent Employee
Birth Date:	☐ Temporary Employee (Please list last day of active service)_____
Type of Request: ☐ New ☐ Name change ☐ Lost/Stolen ☐ Broken ☐ Renewal	Position:
	☐ Supervisor ☐ Sponsor Name: Bldg: Ext.:
FOR PROTECTIVE SERVICES USE ONLY	**CARDKEY INFORMATION**
ID Visualization: ☐ Driver's license State: ☐ Passport Country: Date: Card #: Employee #: Issued By:	DAYTIME ACCESS (MON.-FRI., 6:30 A.M. – 7:00 P.M.) LIST BUILDINGS/AREAS NEEDED FOR DAYTIME ACCESS: _____ ALL HOURS ACCESS LIST BUILDINGS/AREAS NEEDED FOR ALL HOURS ACCESS: _____
	Requestor signature:

Signature of authorizing official:_____ Date:_____

Print Name:_____

NON – DOD VEHICLE REGISTRATION

The information below is requested to help provide a safe and secure environment for all employees and visitors while on the installation.

REGISTRANT INFORMATION

First Name	Last Name	Grade / Rank	Category	Organization

DOB	Sex	Race	Height	Weight	Eye Color	Hair Color	Driver's License #	State

HOME	WORK
Address Line 1:	Address Line 1:
Address Line 2:	Address Line 2:
City: State: Zip:	City: State: Zip:
Phone:	Phone:

VEHICLE INFORMATION

Vehicle Make:	Vehicle Model::
Body Style:	Vehicle Year:
Vehicle Color:	VIN # :

LICENSE INFORMATION

Tag # :	State :	Expiration Date :

INSURANCE INFORMATION

Company Name :	Policy # :	Expiration Date :

Completed by Organization Authorizing Official – FD Form # 190-1

Name: _____ *Signature:* _____ *Date:* _____

*** Completed by Issuing Authority ***

Decal # :	*Exp. Date:*	*Issued By:*

Fort Detrick Form 190-2, dated 23 April 2007